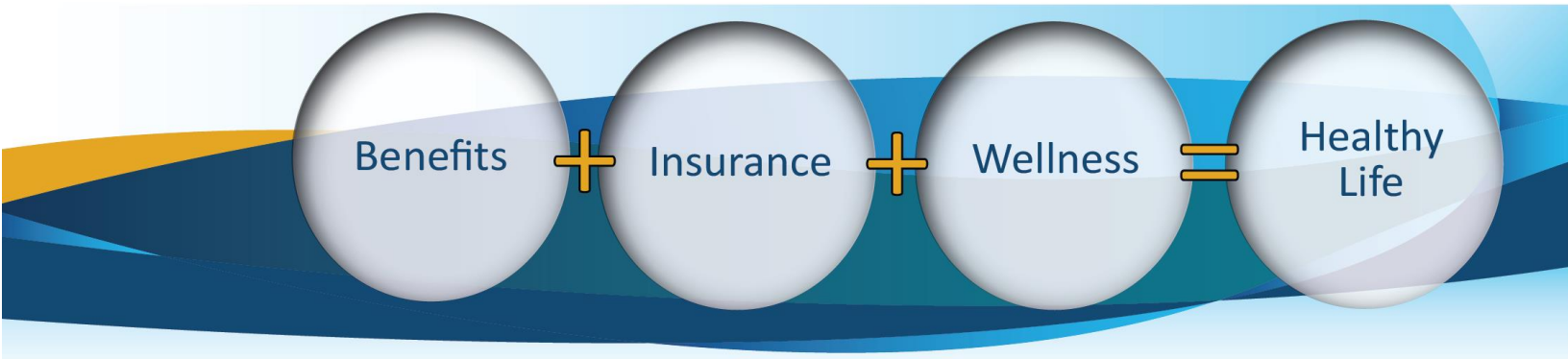
employee benefits guide 2017



ips ADVISORS

NOTES

Contents

Take Care of Your Tomorrow!

Personal needs greatly influence the choices we make every day. Young or old, single or married, our needs differ. That's why the City of La Porte wants to provide you with the freedom to select quality benefit options that work best for you.

It is important that you take an opportunity to review all of your plan options in detail. You will need to carefully consider each benefit option, its cost and value to you and whether it is appropriate for your personal needs. By taking the time to examine all of your options, you will ensure that your benefits meet those needs throughout the plan year.

The City of La Porte values our employees and recognizes the importance of offering benefits that enhance people's lives. With that in mind, we have good news for 2017!

Please Keep This Guide

It is a valuable resource for you throughout the year.

City of La Porte HR Team:

Matt Hartleib, HR Manager (281)470-5025
Lindsey Campuzano, Benefits Specialist (281) 470-5026
Angela Flores, HR Specialist (281) 470-5027

Benefits Resource List

For more information on the wide range of the City of La Porte benefits, programs and tools, contact the following resources:

If You Have Questions About	Contact	By Phone	On the Internet
MEDICAL COVERAGE Directories of network providers, claims status or pre-notification	Aetna	800-872-3862	www.aetna.com
DENTAL COVERAGE	Cigna	800-224-6224	www.mycigna.com
VISION COVERAGE	Avesis	855-214-6777	www.avesis.com
LIFE INSURANCE	Voya	800-955-7736	
DISABILITY INSURANCE	Voya	612-342-7262	
EMPLOYEE ASSISTANCE PROGRAM	UTEAP	800-346-3549 713-500-3327	www.mylifevalues.com www.uteap.org
HEALTH CARE & DEPENDENT CARE SPENDING ACCOUNTS (FSA)	TASC	800-422-4661	www.tasconline.com
RETIREMENT	TMRS	512-476-5576	www.tmrs.org
EMPLOYEE SELF-SERVICE SITE	ADP	Website: Login: City Identifier: Password:	https://home.eease.com firstnamelastname laportetx CALL HR TO RESET

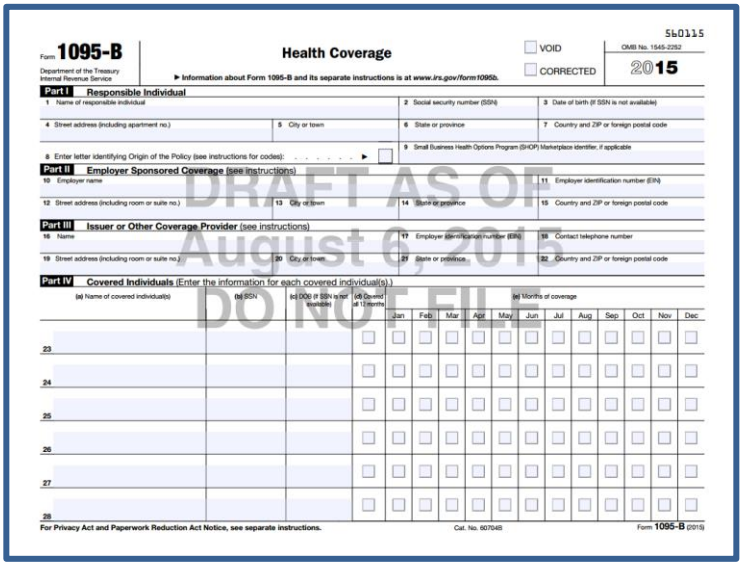
New Tax Forms

In 2016 and 2017, you can expect to receive an additional tax form approximately the same time you receive your W-2. You may be thinking, "Why I am getting this and what do I do with it?"

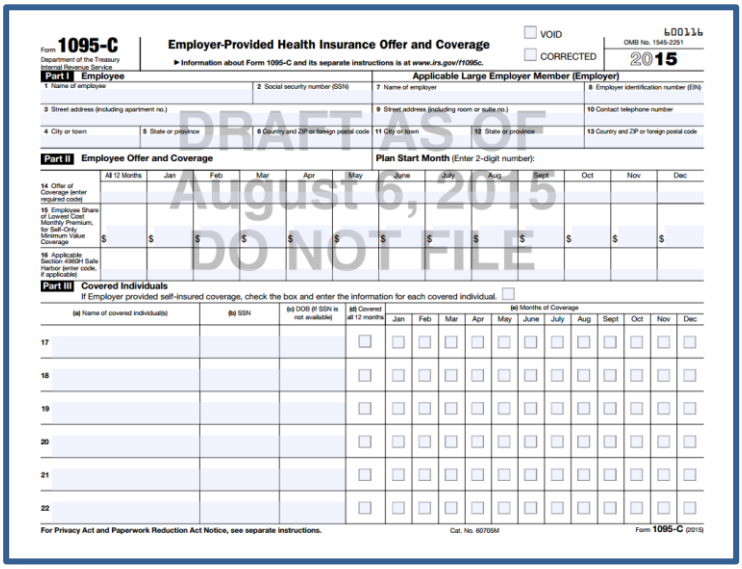
You will use this form in conjunction with your W-2 to file your taxes for 2016. The new tax form addresses two key pieces of legislation, depending on the size of your employer. *Please note you will only receive one form. Which form you receive depends on your group size along with other factors.*

- **Effective January 1, 2014, the "individual mandate" provision under Health Care Reform (also known as individual shared responsibility) requires every individual to have minimum essential health coverage for each month, qualify for an exemption, or pay a penalty when filing his or her federal income tax return.**

- **The employer shared responsibility provisions (also known as "pay or play") require large employers—generally those with at least 50 full-time employees, including full-time equivalent employees (FTEs)—to offer affordable health insurance that provides a minimum level of coverage to full-time employees or pay a penalty tax if any full-time employee is certified to receive a premium tax credit for purchasing individual coverage on the Health Insurance Marketplace (Exchange).**


Form 1095-B Health Coverage
Department of the Treasury Internal Revenue Service
► Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.
VOID CORRECTED
OMB No. 1545-2252
2015
Part I Responsible Individual
1 Name of responsible individual
2 Social security number (SSN)
3 Date of birth (if SSN is not available)
4 Street address (including apartment no.)
5 City or town
6 State or province
7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Policy (see instructions for codes):
9 Small Business Health Options Program (SHOP) Marketplace identifier, if applicable
Part II Employer Sponsored Coverage (see instructions)
10 Employer name
11 Employer identification number (EIN)
12 Street address (including room or suite no.)
13 City or town
14 State or province
15 Country and ZIP or foreign postal code
Part III Issuer or Other Coverage Provider (see instructions)
16 Name
17 Employer identification number (EIN)
18 Contact telephone number
19 Street address (including room or suite no.)
20 City or town
21 State or province
22 Country and ZIP or foreign postal code
Part IV Covered Individuals (Enter the information for each covered individual(s).)
(a) Name of covered individual(s)
(b) SSN
(c) DOB (if SSN is not available)
(d) Covered all 12 months
(e) Months of coverage
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
23 24 25 26 27 28
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.
Cat. No. 60704B
Form 1095-B (2015)
DRAFT AS OF August 6, 2015 DO NOT FILE

The 1095-B form above provides details about an your actual coverage, including who in your family was covered.


Form 1095-C Employer-Provided Health Insurance Offer and Coverage
Department of the Treasury Internal Revenue Service
► Information about Form 1095-C and its separate instructions is at www.irs.gov/f1095c.
VOID CORRECTED
OMB No. 1545-2251
2015
Part I Employee
Applicable Large Employer Member (Employer)
1 Name of employee
2 Social security number (SSN)
7 Name of employer
8 Employer identification number (EIN)
3 Street address (including apartment no.)
9 Street address (including room or suite no.)
10 Contact telephone number
4 City or town
5 State or province
6 Country and ZIP or foreign postal code
11 City or town
12 State or province
13 Country and ZIP or foreign postal code
Part II Employee Offer and Coverage
Plan Start Month (Enter 2-digit number):
All 12 Months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
14 Offer of Coverage (enter required code)
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)
Part III Covered Individuals
If Employer provided self-insured coverage, check the box and enter the information for each covered individual.
(a) Name of covered individual(s)
(b) SSN
(c) DOB (if SSN is not available)
(d) Covered all 12 months
(e) Months of Coverage
Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec
17 18 19 20 21 22
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.
Cat. No. 60705M
Form 1095-C (2015)
DRAFT AS OF August 6, 2015 DO NOT FILE

The 1095-C form describes what coverage your employer made available to you. This form can also be used to address the details of your actual coverage, depending on employer size.

These forms do not subject you to additional taxes; they are merely intended to report to the IRS what medical coverage you were offered through your employer.

Medical Benefits

Effective January 1, 2017

Here is a snapshot of the coverage offered through the 2017 medical plans.

**Employees hired after 1/1/2016 do not qualify for the PPO 500 plan.*

BENEFITS – Aetna		PPO 500*	HF 1000	HF 1500
Deductible	Network	$500 Individual / $1,500 Family	$1,000 Individual / $3,000 Family	$1,500 Individual / $4,500 Family
	Non-Network	$1,000 Individual / $3,000 Family	$2,000 Individual / $6,000 Family	$3,000 Individual / $9,000 Family
Health Fund Allowance		N/A	$500 Individual/ $1,000 Family	$500 Individual/ $1,000 Family
Out-of-Pocket Maximum		Includes Deductible	Includes Deductible	Includes Deductible
	Network	$3,500 Individual / $10,500 Family	$3,000 Individual / $9,000 Family	$4,200 Individual / $12,600 Family
	Non-Network	$7,000 Individual / $21,000 Family	$6,000 Individual / $18,000 Family	$9,000 Individual / $27,000 Family
Co-insurance	Network	80%	80%	80%
	Non-Network	50%	50%	50%
Lifetime Maximum		Unlimited	Unlimited	Unlimited
		You Pay	**You Pay**	**You Pay**
Office Visit	Network	$25 PCP / $40 Spec	Deductible/ 20%	Deductible/ 20%
	Non-Network	Deductible/ 50%	Deductible/ 50%	Deductible/ 50%
Wellness Visit	Network	$0 Copay	$0	$0
	Non-Network	Deductible/ 50%	Deductible/ 50%	Deductible/ 50%
In-Patient & Out-Patient Hosp.	Network	Deductible/ 20%	Deductible/ 20%	Deductible/ 20%
	Non-Network	Deductible/ 50%	Deductible/ 50%	Deductible/ 50%
Urgent Care	Network	$40 Copay	Deductible/ 20%	Deductible/ 20%
	Non-Network	Deductible/ 50%	Deductible/ 50%	Deductible/ 50%
Emergency Room	Network	$150 Copay	Deductible/ 20%	Deductible/ 20%
	Non-Network	$150 Copay	Deductible/ 20%	Deductible/ 20%
Prescriptions	Generic/Brand/ Non-Formulary	$10/$30/$60 20% Spec <$100	$10/$30/$60 20% Spec <$100	$10/$30/$60 20% Spec <$100
	Mail Order (90 day)	$20/$60/$120	$20/$60/$120	$20/$60/$120
Network Website	www.aetna.com	Choice POS II	Choice POS II	Choice POS II

Medical Costs Bi-Weekly	PPO 500		HF 1000		HF1500	
	Non -Tobacco	**Tobacco**	**Non -Tobacco**	**Tobacco**	**Non -Tobacco**	**Tobacco**
Employee Only	$23.18	$46.26	$10.48	$33.56	$6.76	$29.84
Employee & Spouse	$76.50	$99.58	$60.16	$83.24	$48.46	$71.40
Employee & Children	$71.61	$94.69	$55.42	$78.50	$43.96	$67.04
Employee & Family	$85.53	$108.61	$71.82	$94.90	$55.70	$78.78

OneRx App

The OneRx application is a free downloadable app for your smart phone to have instant access to current discounts and coupons for your prescriptions.

Know out-of-pocket costs in real time

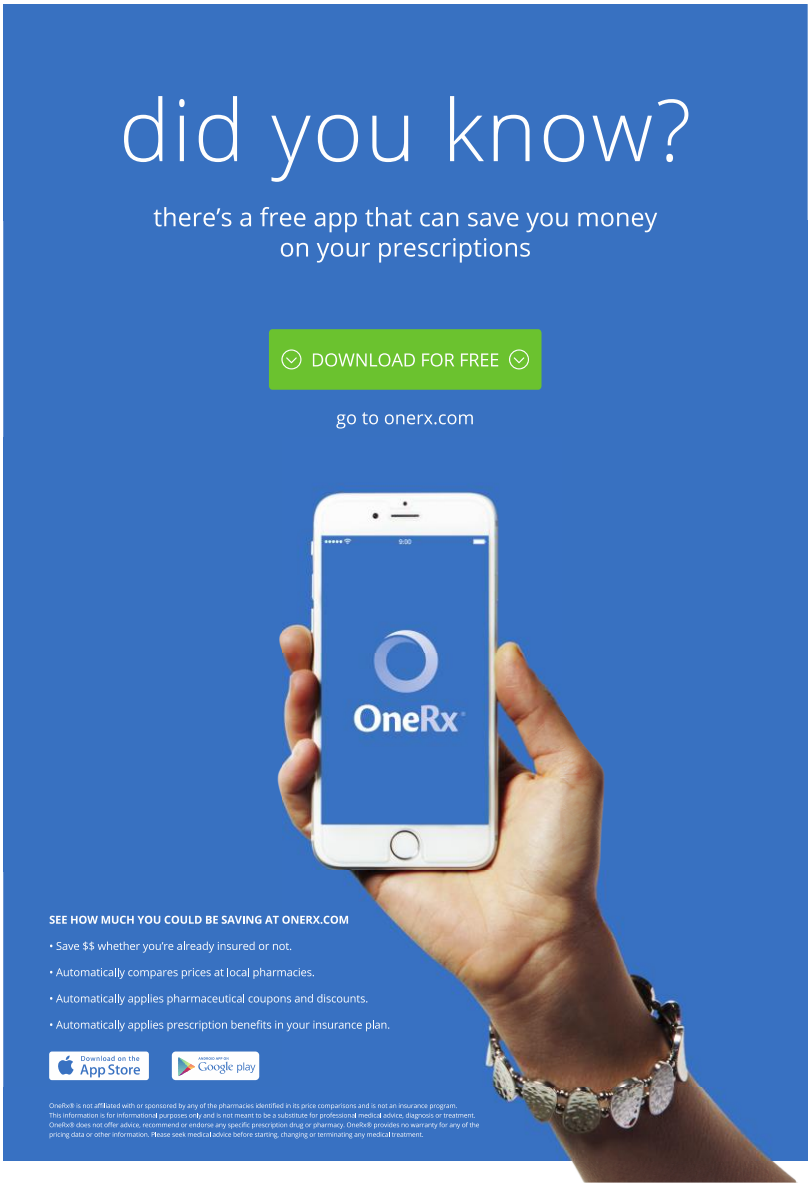
- Employees save money by seeing their personalized out-of-pocket for a drug being prescribed at local pharmacies including any special coupons or discounts you can use.

Be alerted to insurance restrictions

- Know if step therapy or a prior authorization is required before you try to fill the prescription.

Stay up to date on coverage and savings

- Track all medications automatically; be kept up to date on the prescription drug list status and all available savings. The average savings for using the OneRx app is $750!



Doctor, Retail Clinic, Urgent Care or ER?

When you need immediate medical care, the first line of advice has traditionally been, "Go to the nearest emergency room." But is that advice the best course of action? With visits to the ER at an all-time high, wait times have skyrocketed. And emergency room treatments for non-emergency medical conditions contribute to the rising cost of our healthcare. So what are other care settings, and how do you determine which is best?

ALTERNATIVES TO ER CARE

Unless it's a true emergency, you'll likely get quicker medical care at other care settings such as an urgent care center, retail health clinic or walk-in doctor's office. Use these options, where available, when you need medical care quickly, but can't see your regular doctor. These conveniently located, licensed and accredited care settings are staffed with doctors, nurses and physician's assistants. So you'll get quality care, and you'll often pay much less than you would for emergency care. And they're usually open evenings, weekends and sometimes holidays, and can cost about the same as a doctor visit.

- **Urgent care center:** These clinics can usually handle problems that need immediate attention but aren't life-threatening or emergencies, like stitches, sprains and x-rays.
- **Retail health clinic:** Many major pharmacies and retail stores now have these walk-in clinics staffed by medical professionals. Go there when you need convenient, routine care, like for coughs and flu shots.
- **Walk-in doctor's office:** No appointment is needed at these offices, and you usually aren't required to be an existing patient. This alternative is a good choice when you need simple medical care in a hurry, like for mild asthma or minor allergic reactions.

Care Option	Hours	Your Relative Cost *	Description
Doctor's Office	Office hours vary	Usually lower out-of-pocket cost to you than urgent care	Your doctor's office is generally the best place to go for non-emergency care such as health exams, colds, flu, sore throats and minor injuries.
Retail Health Clinic	Similar to retail store hours	Usually lower out-of-pocket cost to you than urgent care	Walk-in clinics are often located in stores and pharmacies to provide convenient, low-cost treatment for minor medical problems like: ear infections, athlete's foot, bronchitis and some vaccinations.
Urgent Care Provider	Generally include evenings, weekends and holidays	Usually lower cost than an ER visit	Urgent care centers can provide care when your doctor is not available and you don't have a true emergency, but need immediate care. For example, they can treat sprained ankles, fevers, and minor cuts and injuries.
Emergency Room (ER)	24 hours, seven days a week	Highest out-of-pocket cost to you	For medical emergencies, call 911 or your local emergency services first.

** The relative costs described here are for network providers. Your costs for out-of-network providers may be significantly higher.*

Doctor, Retail Clinic, Urgent Care or ER? *continued*

	Retail Health Clinic	Walk-in Doctor's Office	Urgent Care Center	Emergency Room
Who usually provides care	**Physician assistant or nurse practitioner**	**Primary care doctor**	**Internal medicine, family practice, pediatric and ER doctors**	
Sprains, strains			■	• Any life-threatening or disabling condition • Sudden or unexplained loss of consciousness • Chest pain; numbness in the face, arm or leg; difficulty speaking • Severe shortness of breath • High fever with stiff neck, mental confusion or difficulty breathing • Coughing up or vomiting blood • Cut or wound that won't stop bleeding • Major injuries • Possible broken bones *Keep the emergency room available for emergencies and keep more money in your pocket.*
Animal bites			■	
X-rays			■	
Stitches			■	
Mild asthma		■	■	
Minor headaches		■	■	
Back pain		■	■	
Nausea, vomiting, diarrhea	■	■	■	
Minor allergic reactions	■	■	■	
Coughs, sore throat	■	■	■	
Bumps, cuts, scrapes	■	■	■	
Rashes, minor burns	■	■	■	
Minor fevers, colds	■	■	■	
Ear or sinus pain	■	■	■	
Burning with urination	■	■	■	
Eye swelling, irritation, redness or pain	■	■	■	
Vaccinations	■	■	■	

Urgent Care Center or Free Standing ER

Knowing the Difference can Save You Money

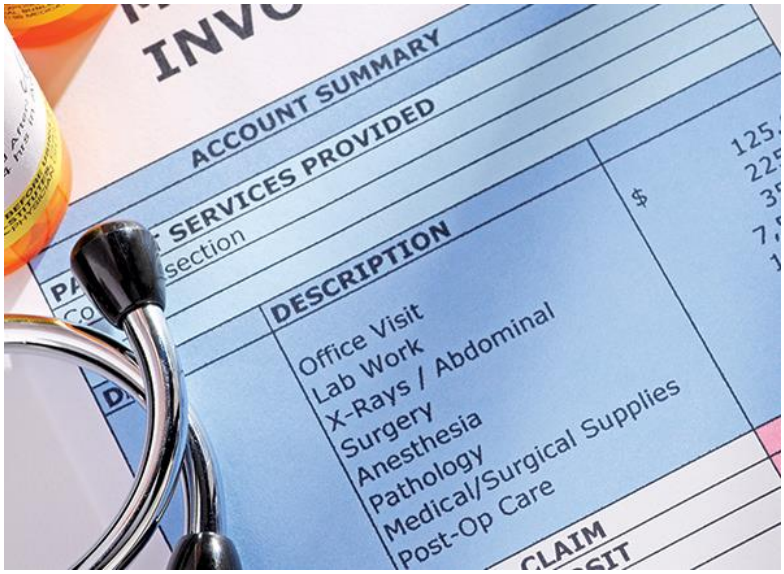
Urgent Care Centers and Free Standing Emergency rooms (ER) can be hard to tell apart. Free Standing ERs often look a lot like Urgent Care Centers, but costs are higher, just as if you went to the ER at a hospital. Here are some ways to know if you are at a Free Standing ER.

Free Standing ERs:

- Look like Urgent Care Centers, but include EMERGENCY in facility names.
- Are usually open 24-hours a day, seven days a week.
- Are physically separate from a hospital.
- Are equipped and operate the same as an ER.
- Are subject to the same ER copay.
- Are staffed by board certified ER physicians.

Surprise Medical Bills

"Surprise medical bill" is a term commonly used to describe charges arising when an insured individual inadvertently receives care from an out-of-network provider. This situation could arise in an emergency when the patient has no ability to select the emergency room, treating physicians, or ambulance providers. Surprise medical bills might also arise when a patient receives planned care from an in-network provider (often, a hospital or ambulatory care facility), but other treating providers brought in to participate in the patient's care are not in the same network. These can include anesthesiologists, radiologists, pathologists, surgical assistants, and others. In some cases, entire departments within an in-network facility may be operated by subcontractors who don't participate in the same network. In these non-emergency situations, too, the in-network provider or facility generally arranges for the other treating providers, not the patient.



I GOT A SURPRISE BILL. WHAT CAN I DO ABOUT IT?

- Call the doctor or provider that sent the bill and discuss your concerns. In most cases, Texas law requires providers to provide an itemized bill on request, so review the charges carefully. Some providers might accept a lower payment.
- For planned procedures, find out in advance whether your providers are contracted with your health plan. This is especially important in the case of facility-based providers, such as radiologists, anesthesiologists, pathologists, and neonatologists. Even if a hospital is in your health plan's network, some doctors who provide services there might not be.
- Call your health plan to make sure the services you will get are covered under your policy. If the services are not covered, you will have to pay the charges.
- Texas law gives patients the right to request estimates of charges. Doctors and other providers and health plans have 10 days to give you the estimates, so you won't be able to get them in cases of emergencies. Some providers and health plans also have cost information on their websites.
- If there aren't any contracted providers available, your health plan might be able to work out a discounted payment. You also might be able to ask your doctor or provider if they'll accept payment options in advance. In some cases, the health plan may be required to make sure you aren't balance billed.

Dental Benefits

Effective January 1, 2017

Here is a snapshot of the coverage offered through the 2017 dental plans.

BENEFITS - Cigna	DHMO*	PPO
Type I – Preventive Services Oral examinations (2 Per Year) X-rays Cleanings (2 Per Year)	$5 Copay See Schedule	No Deductible/ 0%
Type II – Basic Services Fillings Extractions Root Canal	$5 Copay See Schedule	Deductible/ 20%
Type III – Major Services Crowns Removable / fixed bridge-work Partial or complete dentures	$5 Copay See Schedule	Deductible/ 50%
Type IV - Orthodontia Child Only to Age 19	See Schedule	50%
Annual Deductible		
Individual	N/A	$50
Family	N/A	$150
Annual Maximums		
Dental Annual Maximum	N/A	$1,250
Orthodontia Lifetime Maximum	N/A	$1,000
Network Website www.mycigna.com	Cigna DHMO Network	Cigna PPO Network

NOTE: This is a brief summary and not intended to be a contract.

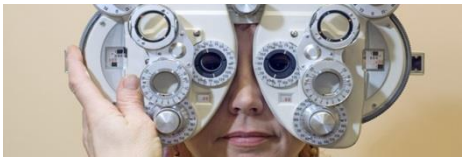
Dental Costs – Semi Monthly	Per Pay Period	Per Pay Period
Employee Only	$5.21	$12.04
Employee + 1	$9.90	$24.00
Employee & Family	$12.18	$44.85

*The DHMO plan requires you to select an in-network primary dentist during enrollment.

For the PPO plan, if you do not enroll when first eligible you will have to be enrolled in the plan for 12 months before Type III and Type IV services will be covered.

Deductions are taken on a pre-paid basis. Ex: deductions during the month of December cover January premium

Vision Benefits



Effective January 1, 2017

This is a snapshot of the coverage offered through the 2017 Vision plan.

BENEFITS		Avesis
Eye Exam	Network	$10 Copay
	Non-Network	Up to $45 Reimbursement
Frames/ Lens		
Single Vision	Network	$25 Copay
	Non-Network	Up to $40 Reimbursement
Bifocal Lenses	Network	$25 Copay
	Non-Network	Up to $60 Reimbursement
Trifocal Lenses	Network	$25 Copay
	Non-Network	Up to $80 Reimbursement
Frames	Network	$65 Allowance
	Non-Network	$65 Reimbursement
Contacts *In Lieu of Glasses		
Network	Medically Necessary	Covered in Full
	Elective	$175 Allowance
Non-Network	Medically Necessary	$250 Allowance
	Elective	$150 Reimbursement
Exam Frequency		12 Months
Lens Frequency		12 Months
Frames Frequency		24 Months
Network Website	www.avesis.com	Avesis Network

NOTE: *This is a brief summary and not intended to be a contract.*

Vision Costs – Semi Monthly	Per Pay Period
Employee Only	$3.01
Employee + 1	$5.32
Employee & Family	$7.89

Basic Life & AD&D Benefits

Effective January 1, 2017

The City of La Porte provides Basic Life and AD&D (Accidental Death and Dismemberment) insurance for you as a full-time employee at no additional cost. If you would like to purchase additional life insurance for yourself and/or your dependents, please see the Voluntary Life Insurance page for more information.

Remember, you can update your beneficiary at any time by making a change online through ADP.

BASIC LIFE/AD&D BENEFITS	Voya
Class Description	Class 1: Exempt Employees, Fire, EMS, Police; Class 2: Non-Exempt Employees; Class 3: City Managers and Department Directors
Basic Life & AD&D Schedule	Class 1: $20,000 Class 2: $10,000 Class 3: $70,000
Maximum Amount	Class 1: $20,000 Class 2: $10,000 Class 3: $70,000
Employee Age Reduction Schedule	65% @ Age 65 40% @ Age 70, 20% @ Age 75, Terminates at Retirement
Waiver of Premium	Included to age 60
Accelerated Death Benefit	50% of Life Benefit
Conversion	Included
Portability	Not Included

NOTE: *This is a brief summary and not intended to be a contract.*

Effective January 1, 2017

HOW MUCH LIFE INSURANCE DO YOU NEED?

Many financial experts recommend you have at least five to eight times your household income in life insurance. To calculate the level sufficient to cover your needs, you should consider your current income and how much it costs to maintain your family's standard of living. You should also consider your current expenses and your family's future financial needs such as the following:

Current Expenses:

- Home Mortgage
- Car Payments
- Credit Card Debt
- Other Debt

Future Needs:

- Child Care
- College Tuition
- Spouse's Retirement
- Routine Household Expenses

After you add your financial responsibilities, how does the sum compare with your current coverage?

Voluntary Life & AD&D Benefits

Effective January 1, 2017

VOLUNTARY LIFE BENEFITS	Voya	
Employee Life Amount	Increments of $10,000	
Class Description	Class 1: Exempt Employees, Fire, EMS, Police; Class 2: Non-Exempt Employees; Class 3: City Managers and Department Directors	
Employee Guarantee Issue Amount	Initial eligible on or after Jan 1, 2011 to Jan 1, 2015: $80,000; **Initial Eligibility after Jan 1, 2015: $150,000**	
Employee Maximum Amount	5X Base Annual Salary to $500,000	
Employee Age Reduction Schedule	to 65% at age 65; to 40% at age 70; to 20% at age 75	
Spouse Life Amount	50% of Employee Amount to a maximum of $100,000	
Spouse Guarantee Issue Amount	$40,000	
Spouse Maximum Amount	$100,000	
Child Life Amount	$5,000 or $10,000	
Waiver of Premium	Included to Age 60	
Conversion	Included	
Suicide Clause	24 Months	
AGE RATED PREMIUMS **(Rates based on Employee/Spouse)**	**Employee** **(Rate Per $1,000)**	**Spouse** **(Rate Per $1,000)**
AD&D Rate:	$0	$0
Life Rate: Up to 24	$0.07	$0.07
25-29	$0.07	$0.07
30-34	$0.08	$0.08
35-39	$0.10	$0.10
40-44	$0.17	$0.17
45-49	$0.25	$0.25
50-54	$0.42	$0.42
55-59	$0.72	$0.72
60-64	$1.09	$1.09
65-69	$2.09	$2.09
70-74	$3.39	$3.39
75-79	$3.39	$3.39
Child Life Rate (Per $1,000)	$0.20	

NOTE: *This is a brief summary and not intended to be a contract.*

Guarantee issue Amounts listed are only available to new hires and their spouses.
All other eligible employees and spouses will be required to submit Evidence of Insurability for any new coverage amount or increase in coverage amount, except as noted.

Disability Benefits

Effective January 1, 2017

The City of La Porte offers full-time employees with short and long-term disability income benefits. The city provides your long term disability. The cost short term disability is paid in full by you, the employee. In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income.

SHORT TERM DISABILITY BENEFITS	Voya – Option 1
Weekly Percentage	60%
Weekly Maximum	$1,000
Benefit Duration	11 Weeks
Accident Benefit Begin	14th Day
Sickness Benefit Begin	14th Day
Monthly Rate per $10 weekly benefit	$0.35

SHORT TERM DISABILITY BENEFITS	Voya – Option 2
Weekly Percentage	60%
Weekly Maximum	$1,000
Benefit Duration	9 Weeks
Accident Benefit Begin	30th Day
Sickness Benefit Begin	30th Day
Monthly Rate per $10 weekly benefit	$0.29

LONG TERM DISABILITY BENEFITS	Voya
Monthly Percentage	60%
Monthly Maximum	$6,000
Definition of Disability	2 Years Own Occupation
Elimination Period	90 Days
Benefit Duration	Social Security Normal Retirement Age
Definition of Earnings	Base Annual Earnings
Pre-existing Limitation	3 / 12
Mental Nervous Limitations	24 Months per Disability
Drug & Alcohol Limitations	24 Months per Disability
Self Reported Limitations	24 Months

NOTE: *This is a brief summary and not intended to be a contract.*

Note: If you are enrolling for Voluntary Disability coverage as a late entrant, you will be required to submit Evidence of Insurability before coverage is approved.

Flexible Spending Account

Effective January 1, 2017

The flexible spending plan is offered through TASC. A Flexible Spending Account (FSA) can provide an important tax advantage that allows you to pay certain health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement FSA

This program lets employees pay for certain IRS-approved medical care expenses not covered by their insurance plan with pre-tax dollars. The annual maximum amount you may contribute to the **Health Care Reimbursement FSA is $2,600**. Some examples include:

- Deductible, Prescriptions & Doctor Visit Co-Payments
- Over-the-Counter Medicines with a Prescription
- Vision services, including Lasik Eye Surgery, Glasses & Contacts
- Hearing services, including hearing aids and batteries
- Orthodontics, Dental deductibles and coinsurance
- Acupuncture

Dependent Care FSA

The Dependent Care FSA allows employees to use pre-tax dollars towards qualified dependent care for children under the of age 13 or caring for elders. The annual maximum amount you may contribute to the **Dependent Care FSA is $5,000** for 2016, (or $2,500 if married and filing separately).

Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

FSA Smart Tips

- Cover any significant medical expenses early in the year using your FSA. You'll spend the remainder of the year paying yourself back with the regular payroll deductions.
- Save your receipts as proof of purchase in order to be reimbursed for your health care expenses from your FSA. So if you are making purchases that are eligible for reimbursement, you'll want to keep them separate from other items.
- Take advantage of the pre-tax savings and use your FSA dollars. Remember, unused money in an FSA at the end of the year is lost.

Medical Eligible Expenses for FSA

Acupuncture	Lifetime Care—Advance Payments
Alcoholism	Lodging - for medical care
Ambulance	Long-Term Care
Artificial Limb	Meals - for medical care
Artificial Teeth	Medical Conferences
Bandages	Medical Information Plan
Breast Reconstruction Surgery	Medical Services
Birth Control Pills	Medicines (excluding over-the-counter without an Rx)
Braille Books and Magazines	Nursing Home
Capital Expenses - ramps, rails, etc.	Nursing Services & Home Care
Car - special design	Operations
Chiropractor	Optometrist
Christian Science Practitioner	Organ Donors
Contact Lenses	Osteopath
Crutches	Oxygen
Dental Treatment (not teeth whitening)	Pregnancy Test kit
Diagnostic Devices	Prosthesis
Disabled Dependent Care Expenses	Psychiatric Care
Drug Addiction - inpatient treatment	Psychoanalysis
Drugs (excluding over-the-counter)	Psychologist
Eyeglasses	Special Education
Eye Surgery	Sterilization
Fertility Enhancement	Stop-Smoking Programs
Founder's Fee - care at retirement home	Surgery
Guide Dog or Other Animal	Telephone for hearing-impaired
Health Institute	Television for hearing impaired
Health Maint. Org. (HMO)	Therapy
Hearing Aids	Transplants
Home Improvements - ramps, lifts, etc.	Transportation - for medical care
Hospital Services	Trips - for medical care
Insurance Premiums - see IRS list	Vasectomy
Laboratory Fees	Vision Correction Surgery
Lead-Based Paint Removal	Weight-Loss Program
Learning Disability	Wheelchair

Employee Assistance Program (EAP)

Effective January 1, 2017

The Employee Assistance Program (EAP) is offered to all employees and immediate family members through UTEAP. The EAP is paid for by the City of La Porte. It is a **completely confidential** counseling program that covers issues such as:

- Legal / Financial
- Depression / Stress
- Drug / Alcohol Abuse
- Emotional Problems
- Financial Pressures
- Grief Issues
- Family / Relationship Problems
- Other Personal Concerns

EAP staff members are available 24 hours a day, 7 days a week, every day of the year by calling 800-346-3549. Staff members are highly trained professionals with experience in family, personal, work related and substance abuse issues.

For online access, please visit **www.mylifevalues.com**.

Username: uteap

Password: uteap

What Constitutes a Qualifying Life Event?

	Benefits Allowed to Change									
Qualifying Life Event	Medical	Dental	Vision	Supp. EE Life	Vol. Sp. Life	Vol. Child Life	Dep. Care	Health Care	Beneficiaries	**Documentation**
Change in marital status: · Marriage · Divorce or Annulment · Legal Separation · Domestic Partner Dissolution · Death of Spouse	√	√	√		√		√	√	√	Marriage Certificate Divorce Decree Final Court Document Notarized Statement of Disenrollment Death Certificate
Change in the number of dependents: · Birth · Adoption · Guardianship of a Child · Death of a Dependent	√	√	√			√	√	√	√	Birth Certificate, Hospital Announcement Adoption Agreement Court Decree for Guardianship Death Certificate
Dependent Becomes Eligible	√	√	√	√	√	√	√	√	√	Provide Name, Social Security Number, and Date of Birth for dependents
Dependent Loses Other Coverage	√	√	√				√	√	√	Proof of Loss of Coverage, such as termination letter; Certificate of Creditable Coverage
Dependent Gains Other Coverage	√	√	√				√	√	√	Proof of Coverage with start date of benefits and name(s) of covered dependents
A change in Employee's, spouse's, or dependent's work hours (including a switch between full and part-time status)	√	√	√				√	√	√	Proof of loss of Coverage due to employment status change, such as a Certificate of Creditable Coverage or letter from the company
Change in Dependent Care Costs							√			Letter from your Day Care Provider
Court Ordered Dependent, add or drop from coverage	√	√	√			√	√	√	√	Contact your Benefits Team Directly

Glossary of Health Coverage & Medical Terms

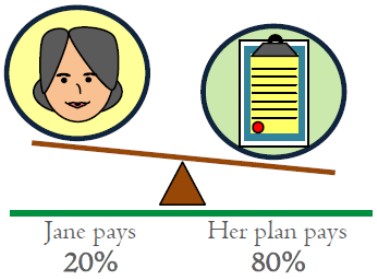
This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

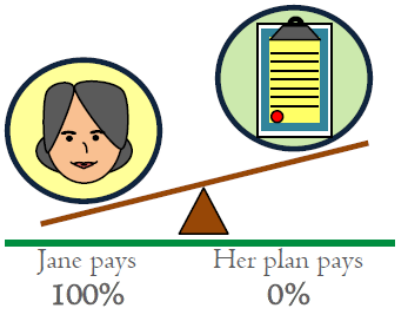
Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance *plus* any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.



Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

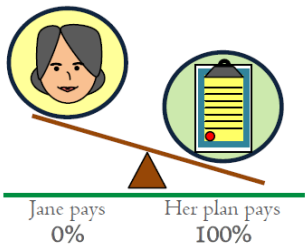
Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Glossary of Health Coverage & Medical Terms (continued)

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.



Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

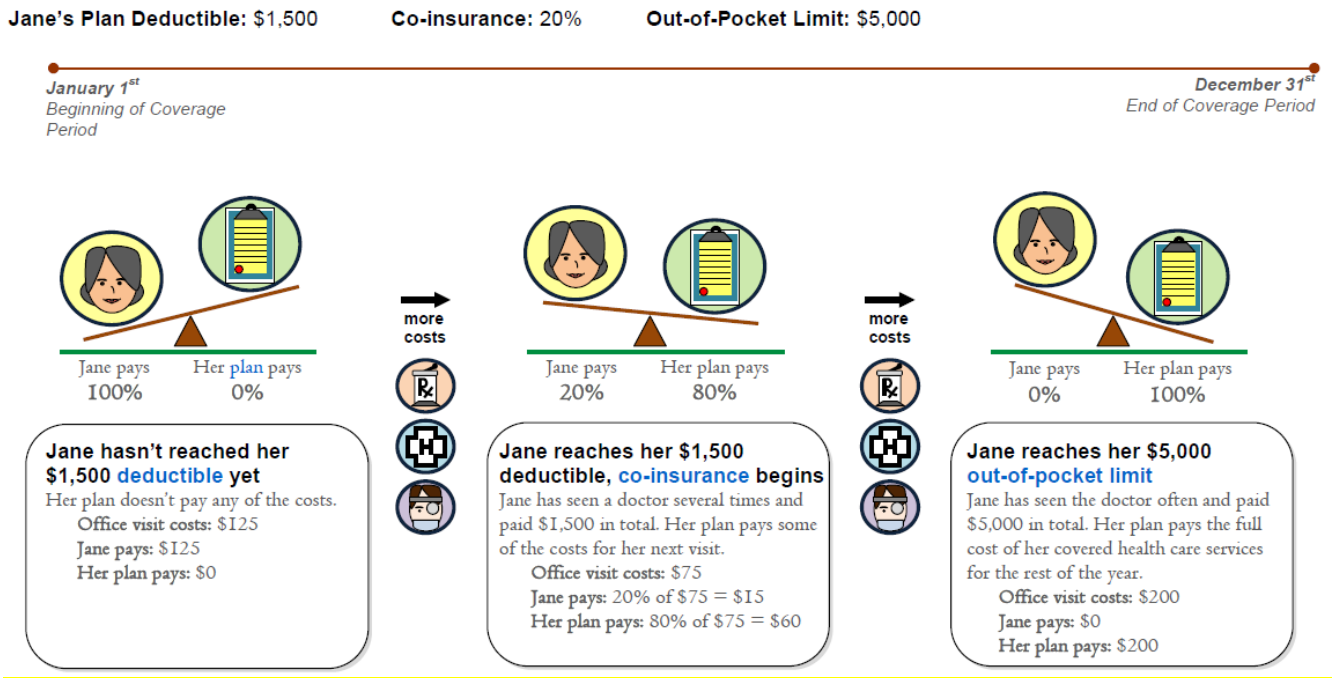
Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example



Annual Notices

Health Insurance Portability and Accountability Act (HIPAA) requires a group health plan to provide a Notice of Special Enrollment Rights annually to all employees who are eligible to participate in the plan.

Notice of Special Enrollment Rights

"Special Enrollment Rights"
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the City of La Porte HR Team.

Women's Health and Cancer Rights

Notice of Rights to Reconstructive Surgery Following Mastectomy
The Women's Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage must be provided in a manner determined in consultation with the attending physician and patient.

This coverage may be subject to co-payments, annual deductibles and co-insurance provisions as is deemed appropriate and as is consistent with the co-payments, annual deductibles and co-insurance for other benefits under the plan or coverage. Federal law requires this coverage. In addition, our Plan will not deny you eligibility or continue eligibility to enroll or renew coverage under the terms of the Plan, solely for the purpose of avoiding this coverage, or to penalize incentives (monetary or otherwise) to an attending provider, to include the provider to provide care to you in a manner inconsistent with the coverage required under the Women's Health and Cancer Rights Act of 1998.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Annual Notices (continued)

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private.

You have the right to inspect and copy protected health information which is maintained by and for the plan for enrollment, payment, claims, and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Benefits Administration.

DISCLAIMER: The HIPAA Privacy Rule is effective beginning April 14, 2003. The Privacy Rule is intended to safeguard protected health information (PHI) created and held by health care providers, health plans, health information clearing houses and their business associates. The provisions of the Privacy Rule have significant impact on those who deal with health information and on all citizens with regard to their personal PHI. Our health insurance broker and all of our contracted plans adhere to the HIPAA Privacy Rule.

This is not a Grandfathered plan.

Important Notice from the City of La Porte
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of La Porte and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City of La Porte has determined that the prescription drug coverage offered by Aetna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current the City of La Porte coverage will be affected. *See* pages 7-9 of the CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/Creditable Coverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current the City of La Porte coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with the City of La Porte and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage….

Contact the Medicare office for further information at 866-746-4234. **NOTE:** You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the City of La Porte changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage….

More detailed information about your Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You Handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

For people with limited income and resources, extra help in paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 1-800-772-1213
(TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2017
Name of Entity/Sender: City of La Porte

Annual Notices (continued)

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2016. You should contact your State for further information on eligibility.

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0964
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: http://flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf

Phone: 1-800-635-2570	Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**

Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

HEALTH INSURANCE MARKETPLACE
COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Part A

General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace ended January 31, 2016 unless you qualify for a Special Enrollment Period.

Can I Save Money on My Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How much is the tax penalty if I don't have health coverage in 2016?

If you don't have health insurance in 2016, you'll pay the **higher** of these two amounts:

- **2.5% of your yearly household income** (Only the amount of income above the tax filing threshold, about $10,150 for an individual in 2014, is used to calculate the penalty.) The maximum penalty is the national average premium for a Bronze plan.
- **$695 per person ($347.50 per child under 18)** The maximum penalty per family using this method is $2,085.

Annual Notices (continued)

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the City of La Porte HR Team.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Part B

Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer name: {Insert Company Name} City of La Porte
2. Employer Identification Number (EIN): 74-6001552
3. Employer address: 604 W. Fairmont Pkwy.
4. Employer phone number 281-471-5020
5. City: La Porte
6. State: TX
7. ZIP code: 77571
8. Who can we contact about employee health coverage at this job? Human Resources
9. Phone number: (if different from above) 281-471-5020
10. Email address: HR@laportetx.gov